Rationing Health Care:
A Rational Approach
Alameda County Experience

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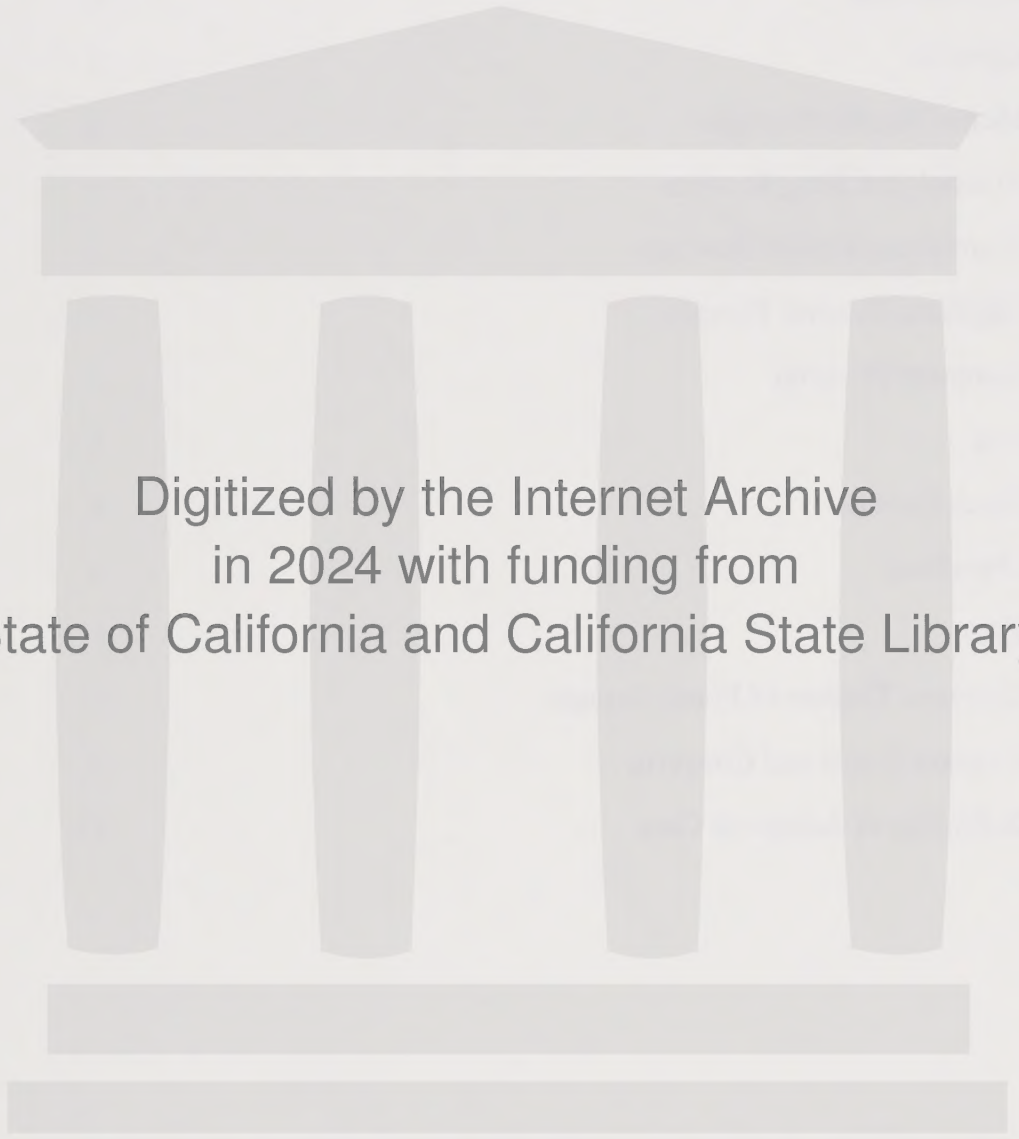
TABLE OF CONTENTS



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ATTACHMENTS

1. List of Focus Groups Participants

2. The Vote Health Coalition Recommendations

3. Management By Priorities: Mental Health Services

RATIONING HEALTH CARE

EXECUTIVE SUMMARY

Everyone expects the most responsive part of a health service to be its emergency rooms, where the critically or acutely ill would be promptly served. Many have been disappointed, however, by the fact that such care is not always available. At Highland General Hospital, patients might wait up to 8 hours in the emergency room for non-acute problems. Approximately 176 patients per month leave the emergency room without being treated because they tired of the long waits. The disposition of these patients, including those with socially transmittable diseases, remains unknown. Highland Hospital's experience reflects a systemwide access problem in Alameda County's health care services and the State. The gap between expectation and reality, need and availability, has worsened in years. Our health care system is in acute crisis.

In response to the crisis, Alameda County Health Care Services Agency (HCSA) undertook a process to examine and prioritize its health care system. This process was modeled after a similar effort in the State of Oregon and drew heavily upon prominent health care providers and advocates in the community. A bio-ethicist was hired to frame the issues and facilitate the work. The decision to pursue such action was precipitated by the growing frustration and ethical dilemma of local governments in having to address increased health care demands with diminishing resources. By reviewing and attempting to prioritize (and in most cases re-prioritize) services and target populations, as well as those not provided or served, Alameda County had hoped to identify specific methods and policies to make our system more equitable and responsive and to educate the public on the limitations of services available, based on current State and Federal budget policies.

Key findings and recommendations to emerge from our work include:

- Current rationing of health care
- Need for preventive care
- System reform required
- Definition of "adequate care"
- Prioritization of new funding
- State and Federal recognition of reality
- Formal adoption of guiding principles

Current Rationing of Health Care

The health care system for the poor and uninsured in Alameda County is already stretched so thin that focus group members felt that rationing, prioritizing or re-prioritizing specific services or procedures relative to target populations or diagnostic categories is impractical and morally indefensible.

A review of current services and efforts by departments within the Health Care Services Agency to manage limited resources and prioritize care, along with a frank and open dialogue among participants regarding the severe limitations of our present

delivery system, all argued against trying to prioritize care further within a rationed system. For instance, reasonable standards of adequate care are simply not being met as evidenced by longer waits in emergency rooms and extended waiting lists; number of patients turned away or denied access through geographical, linguistic, or cultural barriers; abbreviated length of acute hospital stays; and rising rates of acute care patients seen. Faced with these realities, health officials accepted prioritization as a fact of life and of necessary public health management; few believed that our present system had any reserve left to be tapped for reduced services or redirection of effort.

Need for Preventive Care

Health care policy and leadership in this County and State should be redirected toward health promotion, disease prevention, and early intervention aimed at reducing the root causes of increased morbidity among the populations as a whole, but especially among those most dependent upon public support and services.

Our health care system is not only in crisis, it is a self-perpetuating crisis. Failed attempts to control health care costs without compromising access to care have led to a system that de-values the "front-end" of care--prevention, health promotion, and early intervention strategies in favor of tertiary care. Yet individuals denied primary care overfill our emergency rooms, utilizing the most expensive services. More important, the problems of institutional poverty, inadequate housing, and diminished educational and employment opportunities create a culture of despair and hopelessness that breeds substance abuse, community violence, and personal neglect. The system's imbalance feeds on itself as this "front-end" neglect exacerbates the acuity level of our patient population and drives up the cost of care at the "back-end"- the smallest and most expensive. With more dollars channeled in this way, fewer dollars are available for prevention efforts or primary care, thus feeding a cycle in which more health care funds are spent on serving proportionately fewer and fewer people.

We need strong, vital leadership that can articulate and advocate health care policies that integrate social, economic, and public health issues. These policies will hopefully spawn programs that address the root causes of poor health--lack of job and educational opportunities, poor housing, low self-esteem, etc.

In Alameda County, two approaches that reflect this leadership include the Castlemont Corridor Project and the Urban Strategies Council. First, the Castlemont Corridor Project, as conceived by County Supervisor Don Perata, targets high-risk black youth in the East Oakland area where drug use and dealing (especially "crack" cocaine), school truancy and dropping out, high unemployment, and community violence are significant problems.(1) Second, the Urban Strategies Council under the guidance of Angela Blackwell has focused on our future--our children--and on the need for concerted and coordinated efforts among multiple service agencies.(2)

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1) Don Perata, Castlemont Corridor Substance Abuse Prevention Project; Prepared by Castlemont Corridor Coordinating Council, Oakland, Ca., 1988

2) Angela Blackwell, A Chance For Every Child; Oakland's Infants, Children, and Youth at Risk for Persistent Poverty, Prepared by The Urban Strategies Council, Oakland, Ca., February, 1988

Health care leaders need to speak out and promote and participate in developing solutions to the complex problems besieging our health care system today. U.S. Surgeon General C. Everitt Koop best exemplifies this model. Nevertheless, this recommendation recognizes that the leadership responsibility for these changes is not health care's alone, that effective preventive strategies are not readily identifiable, and that many of the major health care problems facing our community (e.g., serious mental illness) are not amenable to preventive efforts. The enormous financial burden of addressing severe health care problems through primary treatment approaches requires that our leadership adopt a prevention strategy that ultimately reduces long-term health care costs associated with preventable illnesses.

System Reform Required

System reform must be a top priority within this County and State, with the focus on reducing administrative and bureaucratic procedures, collapsing funding sources, and improving the coordination and integration of services.

However limited health care resources are, they should not be made more so by the manner in which they are administered, distributed, or utilized. Participants generally felt that the health care system in Alameda County and the State of California was overly bureaucratic and cumbersome and that the County needed to ensure that its system, within the limitations imposed by State and Federal regulations, was as streamlined and efficient as possible. Concerns ranged from problems of categorical funding, personnel hires, equipment acquisition and purchasing, to the delegation of authority and responsibility at the program site levels. Furthermore, people helped by our system have multiple health problems that cross many departmental and jurisdictional lines (e.g., Social Services, Probation, Courts, etc.). Consequently, the health care system, both local and State, must concentrate on interdepartmental coordination, collaboration and planning while encouraging all service providers to concern themselves with the whole person and not just the presenting symptom.

Definition of "Adequate Care"

The County Health Care Services Agency should present an annual "State of the Health" report to the Board of Supervisors, incorporating a profile of the collective health status of Alameda County residents, standards of adequate care, and an analysis of existing services in relation to those standards.

Integral to the financial collapse of the public health care system has been the reluctance of the general public and State and Federal officials to recognize the direct connection between funds committed and services provided and standards met. Whether this is fueled by the belief that the system can provide more service by merely becoming more efficient, effective, cost-conscious, or selective in who is served or by the fear of higher taxes is academic here.

What is important, however, is that any attempt to prioritize, ration, or improve our health care system is contingent upon a clear policy statement of what adequate care is. An effort to define adequate standards in terms of access to care was attempted in this process. Although time constraints necessitated oversimplification and general

estimates of projected costs, the gap between reasonable standards and present service capacity is dramatic and emphasizes again the need for new funds and system reform.

Prioritization of New Funding

Whenever new dollars are available, priority should be given to those populations for whom the consequences of neglect or inadequate care are the greatest. These include by order of priority:

1. **high risk obstetric patients**
2. **minority populations whose access to care is compromised by language and cultural barriers**
3. **high risk children and youth**
4. **the isolated and frail elderly**
5. **minority AIDS patients**

Although the focus groups failed to prioritize either existing populations served or currently available services, all members agreed that the County should prioritize unmet needs and populations and target new funds toward these needs. Critical to this point is support for the principle that public agencies are as responsible for the population they don't serve as well as those they do, for many who are denied care may have needs equal to or greater than those served.

In developing this list, members considered the principles of **equity and equal access** to care by underserved populations, however limited or inadequate that care may be; the **financial impact** of not providing the services; the **human suffering and familial and societal disruption** caused by neglect; and the **availability of adequate services**.

State and Federal Recognition of Reality

State and Federal officials must either recognize and sanction the reality of triage and standards relative to those services that function as gatekeepers of public health care and providers of last resort, or authorize sufficient funds so that standards set can be standards met.

Like those of other communities, Alameda County's inner-city hospitals function as M.A.S.H. units. Their inundation is the best indicator of a health care system out of balance and in crisis. They need support and augmented funding, but no amount of "likely" support will alleviate the need to continually evaluate and treat incoming patients based on comparative acuity and available resources. This reality, and the hypocrisy of judging these services by standards the State and Federal government are willing to set but unwilling to fund, must be laid bare. Similarly, Alameda County residents and providers must also understand that emergency and acute care services will continue to absorb and triage the patient overflow of an inadequate system until the prevention and early intervention strategies begin to pay off and health policy and administrative reforms occur alongside substantial funding augmentations.

Formal Adoption of Guiding Principles

In addition to these findings and recommendations, participants, as a whole,

embraced and expanded upon the principles set forth by the Vote Health Coalition (see Attachment 2). These principles, among others, stress the right of all people to accessible health care; argue that any prioritization process should be broadened to include all County agencies and departments; encourage the State to adopt a similar process; and finally, encourage the public to review this report and participate in finalizing health care policy recommendations for our system.

Rationing is a reality, whether publicized, or not. We have attempted to be open about this process and the ethical dilemmas it poses. Rationing health care is controversial, but it should not be imponderable. We need to define and debate what rationing is, and is not, and face the fact that health care services can no longer be stretched more thinly and that help is not necessarily on the way from either state or federal governments. We need to enter into a public dialogue about how much services we expect or want, and are willing to pay for. With or without outside support, every effort must be made to prioritize.

I. BACKGROUND

In California, Counties, as the "safety net" and legally mandated providers of last resort, are the only governmental bodies that have pragmatic responsibility for the health care of all their people. Their mission includes the provision of direct comprehensive and accessible health care to those in need and unable to obtain care privately; health promotion; disease prevention; and environmental protection. Each of these components in their own right requires vigilance, active engagement of the community, and pro-active, broad intervention strategies. They also depend heavily upon available and committed revenue for their level of success and achievement.

Over the past twenty-five years, scientific and technological advances have dramatically improved the quality and effectiveness of treatment interventions. Standards and costs have risen accordingly and the public expects more from its general and indigent health care system than ever before. Initially, the State and Federal governments promoted and financed this progress. Medicare/Medicaid set the groundwork for a public policy that promised equal access to equal health care for all. As health care costs soared, however, State and Federal government's willingness to sustain this funding commitment began to recede. In the past ten years, counties have seen:

- Medi-Cal reimbursement rates or negotiated contract amendments frozen or allowed to rise at a rate insufficient to attract and retain providers, or at a rate reflective of actual operating costs (e.g., Medi-Cal generally covers about 58% of provider costs);

- Direct State and Federal subventions diminished or not kept pace with inflation (County Medically Indigent Services Program, Mental Health, Revenue Sharing, etc.);

- More State dollars being categorically linked (tied to new mandates, programs, or targeted problems) and thus not available to address broad system deficits;

- Uncompensated care skyrocketing as more working adults have little or no insurance (20% of the employed) and an estimated 6 million Californians have no insurance;

- Much of the efficiency and improved productivity that is possible within public facilities abandoned because costly renovations or construction and new medical technologies have not been directly subvented by the State for years. What support is available (e.g., low interest loans) requires debt financing that can no longer be offset by projected increases in revenues or reimbursements;

- State and Federal mandates and regulations increased without the corresponding allocation of funds for standards set, which require a growing commitment of County funding (Alameda County's net county cost has increased 76%, or $30 Mil., since FY 83-84;

- Local health resources drained by the epidemics of crack cocaine and AIDS, the growing cost of trauma care for gunshot victims of drug wars,

and the failure of the State-initiated "de-institutionalization" of the mentally ill; and,

- Private industry and insurance companies looking for ways to shift the cost of medical care from company to patient, or to the counties as increasingly high health care costs have prompted cost-cutting strategies. Historically, the private sector and insurers have been major partners with the County in subsidizing care for the non-insured or underinsured.

In addition, tax reform measures severely limit the counties' ability to generate local revenue. These factors have widened the gap between what the public needs and demands from its public health care system and what available resources will support.

The reality, then, is that health care for the poor and uninsured is rationed. Clinics and programs operated or contracted by Alameda County all have extended waiting lists. The County Hospital's outpatient services, including emergency rooms, have experienced a 30% increase in visits in just over two years, exacerbating already intolerable waiting times. Patients determined to need an acute medical/surgical or ICU bed can wait up to 16 hours and several days for a psychiatric bed to be available. Everywhere patients are turned away, and what care is provided is often compromised by system overload.

This situation did not happen overnight and counties have not been idle. In addition to steps taken to maximize revenue, improve productivity, and pressure the State to assume greater funding responsibility for the standards and mandates it sets, Alameda County has prioritized services and populations. In this County, departmental efforts have included:

Mental Health Services

- In 1978, outreach and case finding activities were essentially eliminated, resulting in services primarily to those able to seek help on their own or those brought in involuntarily by police

- In 1982, a major prioritization process was developed where care was further restricted (see Attachment 3, Management By Priorities). The entire mental health system was organized around individuals suffering from psychotic and major affective disorders, with minimal, but significant, attention to preventive strategies with the most at-risk populations (e.g., children, ethnic minorities, etc.). Those left with little or no treatment services included many patients with personality disorders, impulse control disorders, bulemia, anorexia, post-traumatic stress disorders, moderate depression, and adjustment disorders--even when domestic violence or assaultiveness are associated features.

- Since 1982, other actions limiting mental health care have included:

  - Exclusion of voluntary clients at inpatient services, and their diminished utilization of psychiatric emergency services;

  - Non-billable services such as case management, rehabilitative day treatment, and prevention programs were eliminated or greatly reduced; and,

- Utilization reviews were initiated to reduce services to severely ill, but stable, people.

Alcohol and Drug Programs

- o From 1976 to 1980, staff replaced expensive clinical/medical programs with a cost-effective social-setting model that emphasizes peer-oriented, non-medical recovery approaches.

- o In 1984, length of stay in a methadone treatment program was limited to increase accessibility.

- o In 1986, site-specific detoxification programs were eliminated.

- o Since 1986, the staff has developed an approach that further utilizes (a) community resources and participation in policy development and client services and (b) a social environment prevention strategy to reduce the need for costly, individually-oriented treatment and recovery.

Community Health Services

- o Over the past five to ten years, CHS has reduced its County-operated clinics from 6 to 5.

- o Public health and health maintenance resources have been redirected to primary care medical and dental services.

- o Patients at prenatal, primary care, and sexually transmitted disease clinics have been limited to slots available, while others have been turned away.

- o "Triage" nursing systems are being developed to handle and prioritize patient requests due to limited clinic slots, while other requests have been referred to alternate providers (e.g., acute care or emergency room services at the County hospitals).

- o The Community Health Education unit and its services have been discontinued.

- o Public health nursing referral guidelines have been redefined to primarily serve only those patients with multiple risk factors, especially high risk obstetric patients and infants, or those with serious communicable diseases (e.g., tuberculosis patients).

Highland General Hospital

- o Highland officials have reduced the average length of stay from 5.1 days to 3.9 days to increase accessibility.

- o Diversion and overload protocols have been utilized to manage and triage patients when public and private hospital beds are filled in the Highland Trauma catchment area. Rounds are made at least three times a day for medical discharge and bumps (moving patients from the ICU to less acute status).

- Acute care services have been expanded by 8 hours per day (6 p.m. to 2 a.m.) to relieve the emergency room, and bed teams have been established to remake beds as soon as patients are removed.

- Triage has been utilized for admitting patients and determining who and when patients are seen in the emergency room.

Fairmont Hospital

- In 1988, Fairmont downgraded its emergency room to urgent care.

Although previous efforts to prioritize and ration care relieved some of the burden at the time, a more open and comprehensive process was needed. The Health Care Services Agency, confronted with the prospects of substantial cuts in health care for FY 89-90 as proposed by the Governor in January 1989, requested the County Board of Supervisors in April 1989 to establish a formal agency-wide prioritization process. This report is the result of efforts to review the county health care system; further prioritize services and populations; and prepare policy recommendations to guide an underfunded, over-mandated system.

II. PROCESS

Focus Groups

Alameda County adopted a prioritizion process similar to that utilized by the State of Oregon, modified to reflect the manner in which the County health care system is organized and the fact that it provides care, and not just pay for it. Bioethicists who assisted the State of Oregon were hired from the onset to help frame the issues, organize and facilitate the process, and assist in preparing the report.

The process called for five focus groups, representing the primary service components of Alcohol and Drug, Community Health Services (non-hospital based primary care and public health), Mental Health, Fairmont Hospital (acute medical, rehabilitation, and skilled nursing care), and Highland General Hospital (emergency, trauma, and acute medical services). Participants were selected by respective department heads from a pool of prominent health care advocates, clinicians, and administrators in the community. Every effort was made to ensure representation by sex, ethnicity, area of expertise, and geography.

The tasks of each focus group were to list the health care needs of people served by Alameda County, outline the services provided as well as the needs not met, assess better ways to respond to the needs of target populations, and prioritize services and populations, where appropriate. The ten member focus groups each met twice for all day sessions, with a week between sessions.

Every group drafted individual reports and selected one representative from each group for an executive group that also included a representative of the Alameda-Contra Costa Medical Association, the Agency Director, and three other members chosen by the Agency Director to provide technical and professional balance. The tasks of the executive group were to review the findings of the five focus groups, address issues not dealt with by the focus groups, and prepare an integrated report for submission to the Board of Supervisors. Responsibility for the final review, scheduling of public hearings, and adoption of any policy recommendations resides with the Board.

Objectives

The process had four key objectives:

- Produce a document that details target populations, services critical to address their health care needs, and estimated costs associated with meeting these needs;
- Publicize the connection between funds allocated and level of services provided, and the gap between what the public expects and needs and what the present funding level will support;
- Promote a broader public dialogue regarding the crisis in health care and the need for major reform; and,
- Influence, however slightly, the State budget process so that further reductions in State subvention to counties do not occur.

III. FINDINGS

Common Themes

Although a major objective of this process was to prioritize existing services and target populations, none of the focus groups were able to reach concensus to do so. The failure to elicit a product reflects both the difficulty of the task and the anguish participants felt over the County's existing health care system.

Many believed that the current system of care for the poor was already over-burdened and inadequate and could not be made more fair or rational through further prioritization. The general feeling was that the current health care system with its limited access for the poor was immoral and that participants could not make the system less immoral by merely reallocating services among the poor and needy. Others objected to the idea of prioritizing or "rationing" care for the poor only, despite the recognition that such rationing occurs, and argued that this prioritization process should occur statewide and address the health needs of all the State's residents. Many feared that a formal prioritization process would leave the system more vulnerable to further reductions in services. Assurances that the prioritization would not be used to reduce care, but rather identify ways to make the system more responsive to those most in need, were not persuasive. The fact that the Health Care Services Agency and its departments prioritize now and would continue to do so in face of increased demands and reduced revenue did not overcome participant concerns or fears.

All groups, however, were willing to identify and prioritize unmet needs in each departmental area, and to argue that new revenues should be directed to specific target populations or services. The executive group reviewed these suggestions and proposed that the following five groups, in rank order of priority, be targeted for new funds or enhancements:

- high risk obstetric patients
- minority populations whose access to care is limited by language and cultural barriers
- high risk youth and children
- isolated and frail elderly
- minority AIDS patients

Criteria used to prioritize patient populations included the economic costs and quality of life aspects of not providing care; the adequacy of existing services proportionate to need; and, of particular importance, the concern over providing equal access to all, even to an inadequate system.

Each of the five focus groups examined the obstacles to obtaining health care by the poor. Participants realized how difficult it is to separate situational life problems from medical problems, and how futile it is to treat medical symptoms without addressing root causes. Beyond the immediate issues of long waiting lists and limited clinic hours, participants felt that access was further compromised by the lack of

culturally and linguistically appropriate services, services for the physically and developmentally disabled, and by the poor's restricted access to telephones, child care, or transportation.

The clearest mandate from all participants called for a comprehensive approach to health care that addresses the root causes of poor health--poverty, inadequate housing and educational opportunities or alcohol and drug abuse; balances emergency services and acute care with health promotion, disease prevention, and primary care; and, emphasizes leadership, teamwork, and comprehensive planning.

Furthermore, each of the focus groups adopted the five principles presented by the Vote Health Coalition. Two groups further recommended a comprehensive annual process of examining the health status of Alameda County and that such efforts include documentation, monitoring, and evaluation of the impact of the previous year's decisions or actions.

In keeping with their primary emphasis on a comprehensive approach but distinct from it, the participants argued for an approach that emphasized the needs of the person. On the one hand, categorical funding and reimbursements based on Diagnosis Related Groups (DRGs) have forced the County system to treat symptoms and not the person, and have discouraged cooperation with other caregivers. On the other hand, single-diagnosis patients are becoming more and more the exception, and it is difficult to distinguish the effects of the physical and social environment and drugs (prescription and non-prescription) on mental and physical illness. A few mental health focus group members wanted to explore the possibility of using "categorical" funding from either mental health or alcohol and drug services to help dual-diagnosis patients by developing creative, multi-disciplinary, multi-problem oriented programs. The Community Health group argued that care coordinators, by being placed at the center of the delivery system, would help re-focus attention on the needs of the person.

Both the Mental Health and Alcohol and Drug focus groups were concerned about the harm caused by labeling and diagnosing people inappropriately. Aside from the social ramifications of labeling, participants felt that too much attention would then be given to symptoms and not the person. At Highland Hospital where people come for emergency and acute care, comprehensive attention is required and not merely symptom relief.

It was clear to focus group members that local health care providers can no longer bear the sole responsibility for health care delivery, that doing so is economically impossible and generally futile. In light of the renewed emphasis on health promotion, disease prevention, and early intervention, the link between community and caregivers is vital. Focus group members argued that public involvement on an ongoing basis was necessary. Any rationing or prioritizing of health care must take place publicly and involve clients, providers, community leaders, and legislators.

Lengthy discussions on access also led to a definition of "adequate care" based on specific timelines by which patients ought to be seen or provided a bed. The decision to define care in this way was primarily pragmatic. First, a detailed definition of care that specifies treatment interventions relative to diagnostic categories or symptomatology was beyond the scope of work and is best left for another process. Second, since one of the values of a definition is its utility as a measuring tool for the public to gauge the extent and responsiveness of care, it was felt that using timelines for broad categories could be more easily understood by the general public. Finally,

this approach allowed the many departments within the HCSA to define standards of access and associated costs in a consistent fashion.

The definition proposed here and outlined in a subsequent section is preliminary. The costs of expanding services needed to meet standards set are estimates. A comprehensive, heuristic definition of adequate care that includes standards of access and an analysis of existing services in relation to those standards must be adopted by the State, and used by the State to develop budget and health care policies.

Program Issues and Concerns

In addition to the common themes emerging from all groups, each focus group identified issues and concerns specific to their department or service area. The major points raised by each group are summarized as follows:

Alcohol and Drug Programs

The Alcohol and Drug Program Focus Group members captured their thoughts in an image that occurred again and again--"We're so busy pulling people who are drowning out of the river, we don't have time to ask why all these people are in the river drowning." Attending to the washed-out bridge upstream requires more emphasis on prevention. The group recommended that the budget for prevention be increased 10% each year to achieve a 50/50 balance between treatment and prevention within five years.

Any comprehensive program must address the social injustices that result in alcohol and drug abuse and emphasize prevention. The type of prevention envisioned is one that centers on primary, rather than secondary or tertiary, prevention. These programs, as outlined in the Alameda County Plan for the Prevention of Alcohol Related Problems (1988-89) and Alameda County Drug Program Services Plan (1988-89), are based on a social or public health model with a strong emphasis on community interventions and participation and the restructuring of social environments to lessen support for alcohol and drug use (e.g., by removing alcohol billboard advertisements in poor neighborhoods).

The concept of "Response Centers" should be developed as an alternative to existing services. These centers feature tighter coordination of services within a targeted area; continuity of care; reductions in bureaucratic regulations to permit rapid program changes to meet evolving community needs and profiles; community outreach and involvement; and aggressive client advocacy to ensure full access to services.

Participants agreed that treatment services must shift in emphasis from a medical and individually-oriented model, unless indicated by need or clinical effectiveness, to a peer support model. Even so, any treatment intervention will be ineffective unless the poor have adequate access to jobs, housing, transportation, or interpreters.

The focus group recommended that greater attention must be given to the following populations: the homeless, teens in the criminal justice system (including probation), women in their child-bearing years, and people who are both HIV seropositive and IV drug users.

Community Health

The Community Health Focus Group argued for the central role of health promotion and disease prevention in a public health care system. Participants discussed the historical roots of the lack of health care access, and saw the decision-making model based on triage, where more and more of the County's funds are spent on emergency and acute care, as destructive. Without health promotion and disease prevention, the population only gets sicker, in turn requiring more money for acute care, which begins the cycle all over again. In addition, lack of early primary care intervention destroys the delivery system's infrastructure, forcing people with non-acute needs to use acute care services, which increases overall patient demand and requires more funds in acute care to "fix" preventable health problems.

The focus group defined health care as a full system that features planning and interagency or systems cooperation. They saw the value of planning a system of local primary care centers using care coordinators to ensure access, continuity of care, and a focus on the person. Coordinators would also be hired to provide multicultural, linguistic, and disability sensitivity. They could assess the skills of patients to obtain health care and refer high risk clients to case managers. Care coordinators could provide advocacy for patients with access problems and with regard to regulations and categorical funding.

Participants advocated a budget increase for Community Health Services proportionate to the unmet needs with 70% of any increase going to primary care and 30% to health promotion and disease prevention.

Consistent with their major goals, members targeted schools, teenagers and women of child-bearing age. They advocated that school-based clinics be reinstated to promote health, prevent disease, provide chronic care, intervene early in urgent care, and, in general, serve a significant population inappropriately served through an acute care model. They also argued that teenagers and women of child-bearing age could benefit greatly from health promotion, particularly around self-esteem, effects of alcohol and drug use, etc.

Mental Health

The Mental Health Focus Group recognized that due to years of chronic statewide underfunding of the mental health system, Alameda County's Mental Health Services has gone much further than the rest of health care in prioritizing services. As a result of a major prioritization process in 1982 (Management By Priorities) and more recent efforts, the department had already narrowed services to adults and older adults with severe and persistent mental illnesses and children with severe emotional disorders. The group further acknowledged that large numbers of non-psychotic people who need and could benefit from treatment are already excluded from care, largely due to stricter admission criteria. Participants noted that acutely mentally ill patients who do not yet meet involuntary treatment criteria are often turned away from the Psychiatric Emergency Service as "not yet sick enough" to require hospitalization, and that all non-24 hour services have waiting lists. None felt that access to these high risk populations could be further compromised through any reduction in funding.

Despite these problems, the group acknowledged and struggled with the reality that other populations, in addition to those traditionally served by the system, are emerging with needs not even minimally addressed. Key among these populations are:

- o ethnic minorities, including immigrants and refugees, where language and culture pose barriers to obtaining adequate care;

- o dual-diagnosis clients, especially those with mental illness and substance abuse;

- o children and adults whose mental health is severely impacted by substance abuse in the community; and,

- o AIDS patients, especially with previously diagnosed mental illness and AIDS dementia.

Focus group members regarded equitable access to treatment within inadequate resources as an extremely difficult problem, but one that must be addressed. The group, therefore, recommended the following:

1. Develop an office of grants development within the HCSA to actively seek additional funding for services;

2. Closely monitor existing County and community-based services to ensure effectiveness and efficiency (providing the most service for those most in need);

3. Provide additional case management resources for consistent follow-up, as well as outreach to those with critical needs;

4. Begin allocating resources proportional to need with a guiding principle of minimizing harm to patients currently receiving services; and,

5. Allow maximum flexibility in using Mental Health and Alcohol and Drug Program funds to develop services for dual-diagnosis patients.

Fairmont Hospital

The Fairmont Hospital Focus Group felt that the hospital was losing its identity as a skilled nursing facility (SNF) providing rehabilitation, and instead served as a multi-service center for the southern area of the County, with little planning or clear decisions to move in new directions. This expanded role, however, has further taxed the capacities of the hospital--waiting times for the clinics and the inadequate hours for working people are sending people to the hospital's urgent care facilities and the SNF waiting list contains anywhere from 20 to 50 people, with the wait approaching a year in some instances. The larger issue, they felt, was the need for a comprehensive view of health care in Alameda County that included the involvement of both the public and private sectors as a means of funding the continuum of resources and sharing the weight of indigent health care.

They argued that unless the issues of health promotion and disease prevention are addressed along with early intervention and post-acute follow-up through local primary care centers, any coordinated approach to health care seems futile. In turn, unless some sort of care coordination is initiated (with case management for high risk people), the public hospitals in the County will continue to be choked by patients better served in less acute facilities.

The focus group saw the need for leadership by the County to provide comprehensive planning, problem-solving, quality assurance, and accountability and to initiate partnerships with providers in the private sector. Comprehensive County planning should include ongoing evaluations of programs or services to maximize performance and effectiveness. Such planning should also involve the community at every level, from educational efforts to community-building to input into decision-making.

As part of the planning effort, participants saw the need to examine Fairmont Hospital's relationship with Highland Hospital in order to clarify roles and increase communication and coordination. Like the Highland members, Fairmont participants wanted to challenge the disincentives for fund-raising and the harm to quality of care caused by Civil Service obstacles to hiring and promotion.

Highland General Hospital

The Highland Hospital Focus Group, representing the "choked" part of the system (or "the narrow end of the funnel," as they termed it), focussed on the increasing number and acuity of the patients they saw. They spoke of non-acute patients using an overloaded acute service and of obstacles to access because of many high-risk patients with multiple diagnoses needing more attention than available resources permit.

Members expressed widespread frustration and exasperation working within the high-pressure Highland Hospital environment, which is fairly typical of large urban public hospitals serving the disproportionately poor and indigent client. Participants were frustrated by the poor physical plant that prevented them from providing care, the lack of facilities available because of the demands of the trauma center, the anxiety-producing ambiance of the emergency room, and the appalling lack of support services.

Much of their concern and frustration, however, focussed on bureaucratic regulations and procedures (especially for obtaining supplies and teaching materials and filling staff positions) that impede efficiency and effectiveness and demoralize staff. The group voted as their #1 priority that they be able to provide service without being hampered by an over-mandated and regulated system or an over-administered structure that loses sight of patient care.

The focus group feared that all of the problems mentioned could jeopardize their retention of good interns and teaching physicians, without whose support health care at Highland Hospital would be severely compromised.

As more patients are turned away from overfilled primary care services in public and private clinics, they begin utilizing Highland Hospital as the first--and last--resort. Not only does this mean that Highland Hospital becomes congested with primary care patients who feel they have nowhere else to go, but they perceive Highland as the center --or the "shopping mall"--of the health delivery system. They felt the system should be enhanced so that patients could obtain their primary care from primary care centers and their acute care and emergency services from Highland, as they were intended.

To do their job as an acute care provider, they recommended that secondary services be done elsewhere; a high-risk center be developed for the southern part of the County; available facilities be purchased or leased for use as local primary care services; and the County support a bond issue for adequate physical facilities at

Highland Hospital. Furthermore, they felt that the Alameda County Health Care Services Agency should be revamped to improve centralized leadership, permit greater attention to health care's mission, or improve communication and coordination.

In addition, they recommended that their perinatal program, in which physicians from Highland work in primary care clinics for the purpose of prevention, early intervention, and enhanced communication, be studied for application to all other sub-specialties, and that the teaching mission of Highland Hospital be expanded to outpatient services. They recommended that there be no cuts in funding for services, and that Highland Hospital be encouraged by the County in its fundraising efforts.

Definition of Adequate Care

To keep the task manageable, and the outcome more pragmatic, the focus groups used "standard of access" as a determining factor in defining "adequate care."

Among many specific criteria that could be used to define "access," the groups focussed on the waiting time needed to receive services by the population in need as a common guideline. To do so, the group focussed on broad and generic categories of services. The following categories were formulated:

1. Primary care
2. Emergency care
3. Acute care
4. Sub-acute care
5. Long-term care

For each category of service a more specific definition was developed and acceptable standards of access were established. The standards operating in the current system were then evaluated and appropriate recommendations were made as to what and how much funding was needed to bring the current system up to standards. The outcome of this effort is reflected in Exhibit 1.

EXHIBIT 1

DEFINITION OF ADEQUATE CARE, STANDARDS
OF ACCESS, AND THE COST ESTIMATES
TO MEET THE STANDARDS

SERVICE COMPONENTS AND DEFINITION	STANDARD OF ACCESS	CURRENT ACCESS	WHAT NEEDED TO ACHIEVE STANDARD	COST OF BRINGING TO STANDARD
I- P R I M A R Y C A R E				
A. Basic Medical services				
Medical care provided by family practitioners, interns, perdiatricians, Ob-Gyns & others for treatment of an illness or maintenance of health, ideally coordinated by a "care coordinator" who provides guidance and makes referrals. Includes reproductive, specialty, social, podiatry, & eyes & ears, and dental services.	Telephone access & Medical Advice on a 24 hour basis	County Clinics: None Community " : Limited Hopital : Limited	For all services reflected in this section, necessary manpower & resources and capitalization to handle volumes & reduce excessive waits, e.g. additional provider sites, expansion of existing sites, additional staff.	$103,783,000
	Appointment within 2 weeks.	County Clinics: 5-6 weeks Community " : 1 wk -4 mths Hospitals: 2- 7.5 weeks		
	Drop-in visits & same day appointments for urgent acute episodic illnesses.	County Clinics: None Comm. clinic : Limited Hospitals : Limited		
	1 week wait for Follow-up care.	County Clinics: 4 wks Comm. clinic : 2 weeks Hospitals: 2- 7.5 weeks		
	new Dental appointments within 3 weeks	County Clinics: 6-9 weeks Comm. clinics : 1 wk-6 mths Hospital : Limited		
	Drop-in visits & same day appoints. for acute & emergency dental problems	County Clinics: very limited Comm. clinics : " Hospital : "		
	routine follow-up Dental care within 2 weeks.	County Clinics: 5-6 weeks Community " : 8 weeks Hospitals: Limited		

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I- P R I M A R Y C A R E				
B. Health Promot.& Prevt.				
Various clinical, educa-educational, nutrirional, and consultation services designed to prevent disease & protect & promote public health.	Early outreach training to prevent transmission of communicable disease	County Clinics: None Community " : None Hospital : None	Staff & associated resources	$10,900,000
	Periodic Public Health nursing follow-up to high risk infants during first year of life.	County Clinics: None Community " : None Hospital : Limited	Sufficient staff & resources for all services reflected below.	CHS: $950,000
	Outreach & assis-tance to high risk groups in obtaining needed health & social services.	County Clinics: Limited Community " : Limited Hospital : None		
	Availability of multi-lingual/cultu-ral county-wide health promotion, & prevention campaign for healthier life style & reduction of risk of disability or death.	County Clinics: Limited Community " : Limited Hospital : None		

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		I- P R I M A R Y C A R E		
C. Mental Health services				
A spectrum of services provided for prevention of hospitalization, stabilization, crisis or therapeutic intervention, & advocacy for clients. these services include Acute day treatment for severely disordered, out patient services for mentally disordered, case management for chronic mentally disordered at risk of rehospitalization, community support services for those in need of living and vocational skills, mental health advocacy, and outreach services	1 mth wait for Outpatient Acute Day Treatment Immediate access for severely disturbed patients & weekly or monthly outpatient visits for stabilized patients. Case management, community support services, & advocacy services available when needed	Adults: Up to 2 mths Children/Adoles.: 4-6 mths Adults: 1-7 week wait list Children: 1-3 month wait list	Staff & resources necessary to handle volumes, e.g. Additional 150 slots for day treatment, add'l 4,000 slots for visits, add'l case managers and rehabilitation programs.	$5,531,649

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II- E M E R G E N C Y C A R E				
A. Medical				
Range of services provided for alleviation of severe pain, or immediate diagnosis & treatment of unforseen medical conditions, which may result in disability or death if services are not immidiately provided.	Care provided immediately for life-threatening conditions; & within 2 hours for non-life threatening emergencies.	Highland: Wait up to 8 hours for non-life threatening conditions.	Sufficient staff & resources to expand capacity.	$12,198,000
B. Psychiatric				
Services designed to provide crisis intervention and immediate therapeutic response to clients exhibiting acute psychiatric symptoms.	Immediate if life threatening. Available as needed if not life threatening.	1-3 hours for non-life threatening	Meets standard	$1,129,284
	Immediate availability of a 24-hour Crisis Intervention	8 hrs/day, 7 days/wk (including mobile unit)	24 hrs/day, 7 days/ week, (including mobile unit)	

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III- A C U T E C A R E				
A. Inpatient				
A wide range of medical surgical, & ancillary services provided for treatment of illness or injuries requiring 24 hour intensive care.	Availability of bed when admission is required.	Waiting time range from 6-30 hours. Lack of staff may preclude admissions.	Sufficient staff & capital resources to increase bed capacity & provide for required consultation & diagnostic services.	$6,163,700
B. Psychiatric Inpatient				
Intensive 24- hour psychiatric treatment services provided to severly mentally disordered experiencing acute symptoms	Availability of bed when admission is required.	Nearly 100% occupancy in current unit results in inappropriate housing of patients in Emergency Room.	Staff & resources to increase bed capacity by 70 beds	$12,296,850
C. Crisis residential care				
Alternative treatment to acute hospital care for treatment of those experiencing situational distress.	Availability of bed when admission is required	100 % occupancy	20 beds	$234,520
D. Inpatient Rehab. svcs.				
Restorative inpatient care including intensive	Availability of bed within 72 hours of	Bed is typically available, however, lack of staff	Adequate manpower	Fairmont: $283,000

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III- A C U T E C A R E				
therapeutic regimes for severely impaired in need of intensive 24 hour svc. to develop function beyond what would occur in the normal course of recovery.	referral.	may preclude admission.		
IV- S U B A C U T E C A R E				
A. Rehab. Services				
Restorative inpatient care including less intensive therapeutic regimes than those provided in acute setting. Length of stay usually does not exceed 3 months.	Availability of bed within 1 week of referral.	Lack of staff resulting in diversion of patients to other facilities	Manpower to handle volume	Included figure in acute service.
B. Mental health				
Transitional inpatient care provided to severely mentally disordered and emotionally disturbed. It is usually used as an alternative or follow-up to hospitalization.	24-hr transitional care within 1-3 days sub-acute care within 1 week Bed available in state hospital within 1 week.	Adult: 2 weeks- 3 months Child: 1-4 months 2 days- 3 moths 2 months- 2 years	Resources to increase capacity by 102 transitional 66 sub-acute, & 36 specialty beds in lieu of state hospital.	$8,461,560

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SERVICE COMPONENTS AND DEFINITION	STANDARD OF ACCESS	CURRENT ACCESS	WHAT NEEDED TO ACHIEVE STANDARD	COST OF BRINGING TO STANDARD
V- L O N G T E R M C A R E				
A. Medical				
Inpatient care requiring medical & therapeutic services exceeding 3 months of stay. This includes services appropriate for chronically ill & severely disabled individuals.	Availability of bed within 1 week of referral.	Neurorespiratory: 3 mths Skilled Nursing: 2-12 mths	Staff & resources to increase capacity by 36 SNF beds & 4 neuro-respiratory	Fairmont: $4,981,000
B. Mental Health				
Inpatient & out of home placements for severely & persistently mentally disordered, and chronically disabled.	1 week wait for available bed in IMD within 1 week. Supplemental Rate Program Board & Care within 1 week.	1-9 mths for IMD 100 additional Board & Care residents have been identified as needing SRP Program	Staff & resources to increase capacity by 50 IMD beds & 100 Board & Care beds.	$2,043,019

IV. CONCLUSION

From the beginning, this has been an arduous and controversial process. Few deny that we don't ration health care for the poor and uninsured now, and almost all argue that our public health care system is in crisis and in need of major reform and augmentation. To advocate for more funds is certainly a supportable and necessary position. To suggest that current health care expenditures may be better spent or at least scrutinized to ensure that those most in need are those most served provokes controversy and concern.

It is understandable that a health care system under siege believes that it will be made more vulnerable through open review and prioritization of existing services and mandates. Nevertheless, the County, as the provider of last resort, must face the ethical issues associated with allocating limited resources.

We have attempted in this process to confront unpleasant realities and propose solutions which include policy changes. We have also tried to define "adequate care" and to educate our community on how far removed we are from reasonable standards. Many recommendations are regrettably general and lacking in specificity needed to provide a real blueprint for immediate change in this County. This process was not initiated as a primer on how to best allocate limited health care dollars. It was intended as the first step toward a broader dialogue, and more importantly, as a commitment to an ongoing process.

As an important step in that direction, the following actions will be recommended or taken:

1. Through the County Board of Supervisors the HCSA will call upon the State of California to adopt a similar process to formulate budgets based on health policies with clear mandates regarding who does, or does not, get served, and with what services. Although the State may fare no better than the County's own process, at least legislators, policy-makers, and other governmental authorities will have to grapple with how truly difficult it is to ration health care for poor and indigent people who already have so little.

2. Interested county health departments should embark on a collaborative effort to define standards of adequate care in the public health care system; develop practical, yet innovative, methods of compensating health care services for the poor and indigent; and recommend health care reforms and policy changes for adoption by the State.

3. Alameda Health Care Services Agency will ask its operating departments to further the process of rationing and prioritizing health care services and to determine whether a humane, equitable system of care is possible through shifts in allocation of resources to serve those most in need. In effect, each department will list priority populations and services, refine standards of access, and recommend allocation policies.

4. Every effort will be made to re-examine preventive health strategies to improve effectiveness and efficiency and encourage the development of innovative approaches. Although new funding is not likely, the HCSA will encourage its departments to aggressively pursue outside sources of

funding and to consider reallocating funds for prevention and health promotion efforts to be directed at priority populations.

Clearly, all those who are concerned about the state of health care services in California must take action. At the very least, there must be open forums on whether the public is willing to finance adequate health care for the poor, and if not, then broad ethical choices must be made about who among the disadvantaged and disenfranchised will be served, and about who shall live, and who shall die. However difficult these moral choices are, they are everyday realities for those who help the poor. Aside from outright denial of health care to the poor, the most repugnant choice available is one where no action is taken, suggesting that the status quo is acceptable and morally defensible.

LIST OF FOCUS GROUPS PARTICIPANTS

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Carol Oakley, Fairmont Hospital
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ATTACHMENT 2

THE VOTE HEALTH COALITION
1411 Fruitvale Avenue, Second Floor
Oakland, California 94601

Date: April 14, 1989

To: Members of Focus Groups of the Health Care Services Prioritization Project
Dave Kears, Health Care Services Agency Director

From: Vote Health Coalition Organizations

Re: Recommendations for prioritization process

Vote Health is a coalition of Alameda County community organizations, labor unions, and health care providers. As organizations enlisted in the fight for decent health care for all, we support the thoughtful, thorough and public analysis of social priorities, so that expenditures of public dollars will reflect the needs and desires of the broadest spectrum of society.

However, we believe that the current design of the Health Care Services Prioritization Project is too narrow in its scope. In its current form there is danger that it will lend legitimacy to the idea of rationing health care on the basis of ability to pay. This is something that we, as health care professionals and advocates, cannot condone.

To avoid the misuse of the prioritization process, it must not be limited to looking at health care only; the entire county budget should be scrutinized. We request that the focus groups petition the Board of Supervisors to establish a separate process to accomplish this objective. In addition, such a significant new policy process must be open to serious comment from a broad portion of the community before finalization. In particular, it is disturbing that no consumers of county health care services have been included in the focus groups. They are the ones who will bear the consequences of these decisions, and their opinions are therefore crucial. And finally, the scope of rational prioritization should extend to the state and national level; to keep it limited to the county does not provide an accurate picture of the choices that are being made about our tax dollars.

In the context of a nation-wide health care crisis, Alameda County's innovative steps to rationalize expenditure of public health care funds have attracted national attention. The decisions that are made and the principles embraced by you, the members of the Focus Groups, will have national impact. We call on you to make the most of the leadership role you are in, to see the broader implications of this prioritization process, and to adopt the following principles at your first meeting:

1. Ask the Alameda County Board of Supervisors to examine the entire Alameda County budget, not just the health care services budget, before making decisions based on these recommendations.

2. Ensure broad community participation, especially of recipients of county health care services, by holding public forums throughout the county.

3. Make recommendations for restructuring the system that will lead to more efficient use of resources and more effective capture of outside resources.

4. Call upon state officials to pursue a prioritization process for the state budget, using these guidelines.

5. Resolve that all people have a right to accessible, affordable health care.

We hope you will adopt these principles, and we wish you courage, clarity and endurance as you undertake this difficult project.

VH/VHMM49TH

The Vote Health Coalition urges the members of the Focus Groups for the Health Care Services Prioritization Project to adopt the following principles as amendments to your mission statement:

1. Ask the Alameda County Board of Supervisors to examine the entire Alameda County budget, not just the health care services budget, before making decisions based on these recommendations.

Why should health care be the focus of this prioritization process? Health care is not the biggest recipient of county dollars; there certainly must be other areas of public expenditure that are controversial. The answer is that the need for public health care is so much greater than the resources available for it that medical professionals are forced to make life and death decisions daily. **Why should our response to this dilemma be to try to figure out more logical ways to decide who shall die?** That is no answer at all. We need to make the starting point for this prioritization project the entire county budget, not just the health care portion. Further, the county should develop and aggressively pursue a strategy to capture more funds from the state, so that we will not have to make these unconscionable choices.

Out of a total county budget of $909 million for FY 88-89, health care was allocated only $170 million (19%). Public protection services received $289 million (32%). However, **the net cost to Alameda County taxpayers for health care services was only $63 million**, because third-party payments (e.g., private insurance, Medi-Cal) made up the difference. **Public protection services cost county taxpayers $233 million.** Our county tax dollars spent on health care services go further than dollars spent on public protection services. Money spent on health care is money well spent.

2. Ensure broad community participation, especially of recipients of county health care services, by holding public forums throughout the county.

Even the most objective and well-trained professionals cannot be sure they have the answers to such difficult questions as whether it is more important to teach a teenager to avoid AIDS, to teach a mother to care for her unborn child, or to teach a middle-aged father to prevent heart disease. Such critical decisions must not be made without significant input from the people affected by them, especially the consumers of public health care. The conclusions that come out of the Focus Groups and the Executive Group should be discussed in depth in public meetings held in the evening and in all parts of the county to allow broad participation. The Executive Group should then take this input into consideration in designing their final report for the Board of Supervisors. Such a community process would only need to extend the timeframe by two or three weeks, and the added legitimacy that it would lend the results would make it worth the wait.

[illegible] Health Coalition • 1411 Fruitvale Avenue, Second Floor • Oakland, California • 94601

3. Make recommendations for restructuring the system that will lead to more efficient use of resources and more effective capture of outside resources.

The current structure of health care services in the county is inefficient in many ways. In the course of the Focus Group's discussions, there will arise innovative ideas for reorganization and streamlining of the system. These ideas can become the groundwork for a more efficient health care system for Alameda County that could save money and staff resources.

4. Call upon state officials to pursue a prioritization process for the state budget, using these guidelines.

The prioritization process also has to aim its fire at the state and federal governments. It is at this level that the decisions to underfund the Medi-Cal and Medicare programs are made. The Focus Groups and Executive Group should call on Governor Deukmejian to open up the State budget to a similar process, as has been done recently in Florida and Oregon. However, a statewide prioritization process should be conducted only under the same guidelines as are outlined here; the first guideline calling for the entire budget to come under scrutiny is particularly important. The state should also develop and aggressively pursue strategies to pressure the federal government for more funds for health care and other human services.

5. Resolve that all people have a right to accessible, affordable health care.

Every person in Alameda County and in the rest of this country should have access to comprehensive, affordable, high quality health care services. The best way to ensure this would be through a state or national health care program.

By engaging in a prioritization process that only considers the county's public health care programs, we in effect give support to the rationing of health care on the basis of ability to pay. This will serve to further restrict health care for those who already have the least access to care. With a universally accessible health care plan, the prioritization process could instead lead to elimination of medically irrelevant, administrative aspects of our current system which consume a disproportionate share of health care dollars. This would lead to a more equitable, efficient and rational distribution of medical services.

ATTACHMENT 3

Alameda County
Health Care Services Agency
MENTAL HEALTH SERVICE

MANAGEMENT BY PRIORITIES: MENTAL HEALTH SERVICES

David J. Kears, L.C.S.W.
Director

January 20, 1982

MANAGEMENT BY PRIORITIES: MENTAL HEALTH SERVICES

CONTEXT

Over the past twenty years, the Mental Health System in California has undergone significant changes. The most important of these changes occurred with the passage of the Short-Doyle Act in ~~1967~~ 1957. With the passage of this legislation, the major responsibility for the care of the acute and chronically mentally ill was transferred from the state to the local community. The magnitude of this transfer of care is demonstrated by the fact that in the 1950's there were over 30,000 patients in state mental hospitals whereas today there are fewer than 3,000.

As part of the move to community care, major legal changes were also made to the criteria and procedures for involuntary detention via the Lanterman-Petris-Short Act of 1969. It was hoped that the changes in commitment criteria, coupled with the move to community care, would both broaden the scope of mental health services as well as enable the chronically mentally ill to more effectively "integrate into society." During the early 1970's, these hopes were largely fulfilled with the development of a variety of quality and responsive local mental health programs. However, towards the end of the 1970's, the cost to effectively care for both the chronic and high-risk mentally ill populations began to exceed available resources. Added to the demand for mental health services was the emergence of new populations such as the growth in the Hispanic, geropsychiatric, and Asian refugee and immigrant populations for which little or no local resources were available.

The frustration of increasing service demands, coupled with decreasing resources, is evidenced by the complaints of families, local police departments, and mental health providers. Unfortunately, these complaints are likely to grow as the prospect of declining resources continue through the 1980's. The major factors and trends that will continue to negatively influence the availability of mental health resources in the 1980's are:

CONSTRAINTS ON COMMUNITY MENTAL HEALTH CARE

- Cost-of-living adjustments passed on by the state to counties have been, and will likely continue to be, insufficient to cover local costs of inflation. Counties will be faced with the burden of augmenting local mental health budgets above the mandated 10 percent/15 percent matches or reduce the scope of needed services. The prospect of the latter was evidenced last year with the closure of Amber House and termination of the psychiatric residency program at Highland Hospital. For FY 1982-83, insufficient state cost-of-living adjustments are projected to produce a $300,000 budget deficit, assuming a 6 percent state cost-of-living and a 9.5 percent county salary and benefit increase.

- The state-administered Short-Doyle/Medi-Cal system will continue changes designed to comply with federal Medi-Cal regulations. The initial hope of this system, with its emphasis of budget and internal utilization control,

is giving way to a system of cost containments and external utilization controls that will force counties to adopt more restrictive guidelines as to who is served and what type of services are provided.

- Cost of local hospital care continues to increase at annual rates in excess of 14 percent. This rate of increase is far in excess of the 9 percent reimbursement rate increase for acute mental health care. Unless a more cost effective method of delivering acute mental health care is achieved, further reductions in outpatient and community support programs will be inevitable.

- Access to state hospitals will continue to be restricted, both in terms of the number and characteristics of patients admitted. Even if no reductions in state hospital beds occur, the recent increases in judicial commitments, e.g., P.C. 1026, not guilty by reason of insanity, to state hospitals will displace available beds and force counties to get by with less. Added to this burden is the fact that state hospitals are experiencing staffing and funding problems which has resulted in curtailment of programs for patients with special treatment needs. Nowhere has this been more evident than the fact that Alameda County has essentially been unable to admit non-ambulatory geriatric patients to Napa State Hospital for the past two years. Similar access problems have occurred with high-bail criminal justice patients and young adults suffering from brain trauma. The State Department of Mental Health is also currently conducting a study to determine whether or not any children or adolescents should be served by the state hospital.

- The state will continue to hold counties accountable for a fixed state hospital allocation with fiscal penalties imposed for any use in excess of their base allocation. Recent decisions by the State Department of Mental Health indicate a move to monitor state hospital utilization on a quarterly basis with corresponding adjustments to local program allocations to compensate for increased utilization. Counties that are unable to stay within their base state hospital allocation will have to either reduce local programs or augment local budgets to pay for excess state hospital use.

- Any potential for new state funding will be restricted to, primarily, performance contracts that tie specific programs to actual reductions in state hospital days. This has been essentially true for the past two years and limits the development of innovative programs for patient populations not served by the state hospitals. Local unmet needs will, of necessity, have to be addressed through the limited options of redistribution of existing resources.

- The number and severity of mental health problems confronting local communities are increasing as major social and economic resources are eliminated (employment, financial assistance, child care and nutrition programs). Consumers of mental health services, particularly children, are frequently involved with other service systems--courts, probation, schools, social services, health. Reduction or elimination of services from another system affects users of mental health services by intensifying their problems and decreasing access to necessary supports.

MANAGEMENT APPROACHES IN THE ERA OF DECLINING RESOURCES

The problem of insufficient cost-of-living versus the actual cost of service is primarily the result of the cost of county-operated programs. The average cost increase in county-operated mental health programs during the last four years has been in excess of 10 percent. The average increase in mental health reimbursements for the last two years has averaged only 8 percent. Where this reimbursement gap is less than 1-2 percent of the Mental Health budget, the Department of Mental Health will attempt to minimize impact on client services through a series of management efforts aimed at improving the cost effectiveness and productivity of county services. Among the specific actions already implemented are:

- County-operated Inpatient Service

  In this program area, the Mental Health Service has begun, via contract, an architectural and program study of the Highland psychiatric inpatient and emergency programs. The current physical location of the inpatient and emergency services, with its long and narrow wards separated from each other, prevents implementation of more cost-effective staffing patterns. The study will review architectural options at Highland Hospital designed to enhance the physical location of these services to improve patient flow and cost-effective staffing patterns. Also included in this study will be an analysis of the feasibility of contracting out the psychiatric inpatient and emergency services.

- County-operated Outpatient Programs

  In this program area, the financial concern is primarily the result of continuing restrictions on the state-administered Short-Doyle/Medi-Cal system. The actual cost of providing county-operated outpatient care has, in the last two years, begun to outpace the rates of reimbursement increases for these types of services. This gap in reimbursements exists even though the county mental health program's billing and collection system is considered to be one of the best in the state and has been adopted by four other counties. The Mental Health Service believes the most viable management option to address this problem is to increase the productivity of county-operated outpatient programs consistent with the new reimbursement standards being developed by the State Department of Mental Health. To achieve this goal, the Mental Health Service has implemented an effective monitoring system to improve the productivity of county-operated service. Standards have been set for each of our services and productivity levels are assessed on a quarterly basis. Administrative procedures, including peer review, chart recording standards, and quality assurance, have also been streamlined. The results of these efforts will be of major assistance in deciding where program reductions must occur to address a $300,000 deficit in the 1982-83 budget, resulting from the reimbursement gap. These reductions will align the cost of county-operated outpatient programs with state and third-party reimbursement limits.

- Administrative Services

  Administrative and support services have been consolidated to reduce cost and maximize service efficiency. Grants have been actively pursued with the commitment that added revenue will be used to offset existing costs rather than to expand the administrative workforce.

MENTAL HEALTH PROGRAM PRIORITIES

The County Mental Health System provides direct care and counseling intervention to over 10,000 individual clients and families each year. Any substantial reductions in state and federal allocations will require the scope of these services to be reduced. It is our hope that the overall cost-of-living problem can be effectively dealt with through competent and creative management. However, the County Mental Health System faces an even greater challenge in dealing with reduction in state and federal program allocations. For FY 1982-83, the Mental Health program will lose its remaining NIMH funds ($350,000). There is also the possibility that ACTEB funds for vocational training for mental health clients will be severely reduced ($113,000). In addition to these known problems, the cost of living for the Short-Doyle system is directly tied to the financial uncertainties of the State of California. To effectively manage these problems requires the Mental Health Service to have a clear sense of program priority and to effectively communicate its recommendation to your Honorable Board and the public.

To achieve this, the Agency recommends that all services be evaluated and retained, expanded, modified, or reduced, based on the dual criteria of priority population served and impact of services provided. Data exists or can be collected on all contracted and county-operated programs to substantiate these criteria. These criteria also affirm the primary obligation of public mental health services to treat those patients for whom no private resources are available and for whom the absence of intervention will be life-threatening, disruptive to normal development, or result in more costly care.

In the following sections, the principal mental health populations are defined and listed in order of priority. Basic service categories are also described and listed. Finally, service categories are matched with the priority populations and assessed to determine which services are essential, needed, and optional.

- Mental Health Patient Pooulations in Order of Priority

  1. *INDIVIDUALS WITH LIFE-THREATENING CONDITIONS* - This refers to those individuals who, as a result of a mental or emotional disorder, are dangerous to self or others, or are gravely disabled. The primary entry point for this population is our Psychiatric Emergency Service, where from 700 to 800 individuals are seen each month. Treatment provided is almost always on involuntary basis, with the most frequent modes of service offered being acute emergency, inpatient, and locked sub-acute care.

2. *THE HIGH-RISK MENTALLY DISORDERED* - By far, this represents the largest single population served by our mental health system. In essence, it is a population of individuals who, in the absence of intervention, may deteriorate to the point where their behavior becomes "life threatening." Capacity to independently provide for shelter, health and sustenance is usually minimal to non-existent. The majority of adults in this category have an extensive history of psychiatric care, including emergency visits and hospitalization. Children under 18 with mental disorders are likely to have had a history of extensive involvement with Protective Services or Probation, and various out-of-home placements include hospitalization. Common clinical manifestations for all ages include persistent delusional ideation, chronic depression, poor judgment, and bizarre or inappropriate behavior; children may alternatively exhibit significant developmental delays and serious educational deficits related to their emotional disturbance. Services generally are provided in a variety of community settings and on a voluntary basis.

3. *INDIVIDUALS IN CRISIS* - This refers to that segment of our various communities, e.g., ethnic minorities, elderly, etc., who, in response to stressful situations, experience significant emotional or mental dysfunctioning. The stressful situation may be as in the loss of a job, marriage dissolution, loss of parent, immigration status, or resettlement trauma. Common complaints or presenting problems for adult and children may include major changes in sleeping or eating patterns, loss of sleep, lack of motivation, isolation from significant others, and persistent anxiety. Individuals served may or may not have had a prior history of psychiatric care, and clinical conditions do not usually deteriorate into life-threatening behavior if interventions are not provided. Individuals seen are generally treated on time-limited outpatient basis.

4. *TARGETED AT-RISK POPULATIONS* - This population is distinguishable from #2 in that the "at risk" refers to the prevalence of highly stressful social and economic indicators among traditionally unserved and underserved groups, e.g., ethnic minorities, children, elderly, single parent households, recent ethnic minority immigrants/refugees, monolingual, etc., that are predictors of a high incidence of mental or emotional illnesses. The objectives are more to prevent major emotional dysfunctioning by enhancing existing community support systems. Consultation, education, and community outreach are the primary mode of services offered.

5. *GENERAL POPULATION* - This is not so much a prioritized population as it is an acknowledgement that our county mental health system should provide the general public with basic education, information in predominant languages about what mental health resources are available and to whom. This necessitates both a knowledge of public and private resources and a communication network that can promptly and effectively respond to inquiries.

Publisher's Note: Manuscript not available.

8.	*CONSULTATION, EDUCATION, AND COMMUNITY OUTREACH SERVICES*	Refers primarily to educational and consultative services to community and ethnic minority groups for whom access to traditional service providers are either limited or contraindicated. Examples include workwhop on effective parenting, conflict resolution, and problem-solving skills.
9.	*INFORMATION AND REFERRAL*	Refers to the basic provision of information to the public on mental health or related matters. Contacts are generally brief and service is essentially offered by all providers.

Mental Health Priority Budgeting System

Almost all mental health providers offer more than one of the listed services, and most treat more than one target population. Individual clients and/or families are also likely to receive multiple services during a course of treatment. *Provider services become essential, needed, or optional based on the needs of prioritized populations and the fiscal and clinical consequences of not providing care.* The key fiscal concerns are, by necessity, whether or not the service functions to avoid more costly care and/or enables the county to live within its state hospital allocation or to achieve other fiscal mandates. The key clinical concerns are whether or not the service prevents further deterioration of clinical conditions or family structure and/or results in improvement such that a lower level of care or no additional care is required.

In this context, *ESSENTIAL SERVICES* are those that meet both the fiscal and clinical criteria; *NEEDED SERVICES* meet the clinical criteria but not the fiscal criteria; and *OPTIONAL SERVICES* address important clinical needs but do not prevent life-threatening behavior, major family disruptions, or over utilization of state hospitals.

The importance of a specific mental health service is determined by the extent to which essential or needed services to priority populations are delivered. Information is available or will be collected over the next several months on all service providers that indicates which of the listed services they provide and to which priority populations. Using this assessment tool, specific providers will then be evaluated, and budget recommendations can be made accordingly. To illustrate:

> *Adult outpatient clinics, by design, serve "high-risk" clients and individuals and families in crisis. They also provide for a myriad of services ranging from information and referral, crisis counseling and intervention, to clinical maintenance and advocacy. Let us assume that in our review of a particular service site it is determined that 60% of clients served are high-risk clients and 40% are crisis cases; furthermore, all services provided to the high-risk populations are judged essential services, but only half of services provided to*

crisis clients are determined to be either essential or needed. It would then be our judgment that the service cost of that provider could be reduced by 20% without negatively impacting the critical mandate of Mental Health.

It is important to stress that this approach is offered as a guideline in recommending unavoidable program reductions. It is not a precise formula in which data can be fed to produce specific recommendations. It must be tempered by judgments as to what treatment components must be maintained in order to provide for a system of care. In addition, there are fluctuations in the size and needs of priority populations that must be anticipated and responded to. The application of this approach, coupled with responsive management, however, should ensure that essential mental health services are identified and maintained.

	Life-Threatening Behavior	High Risk Clients	Individual In Crisis	Targeted Groups	General Population
Protected care	essential	needed	optional	not applicable	not applicable
Sheltered, supportive care	essential	essential	optional	not applicable	not applicable
Linkage, placement & case management	needed	essential	optional	optional	not applicable
Rehabilitative and habilitative care	needed	essential	needed	not applicable	not applicable
Clinical maintenance and advocacy	needed	essential	optional	clinical maintenance is not applicable; advocacy is needed	not applicable
Crisis counseling & intervention	essential	essential	essential	optional	not applicable
Clinical assessment and disposition planning	essential	essential	essential	not applicable	not applicable
Consultation, education and community outreach	optional	optional / essential*	optional / essential*	essential	optional
Information and referral	essential	essential	essential	essential	essential

*Consultation, Education and Community Outreach Services are essential for ethnic and minority groups, who ... mental health resources because of historical, cultural, and linguistic reasons.

	LIFE-THREATENING BEHAVIOR	HIGH-RISK CLIENTS	INDIVIDUAL IN CRISIS	TARGETED GROUPS	GENERAL POPULATION
ESSENTIAL	- Protected care - Sheltered, supportive care - Crisis counseling and intervention - Clinical assesment & disposition planning - Information and referral	- Sheltered, supportive care - Linkage, placement & case management - Rehabilitative & habilitative care - Clinical maintenance and advocacy - Crisis counseling and intervention - Clinical assesment & disposition planning - Consultation, education & community outreach* - Information and referral	- Crisis counseling and intervention - Clinical assesment & disposition planning - Consultation, education & community outreach* - Information and referral	- Consultation, education & community outreach - Information and referral	- Information and referral

	LIFE-THREATENING BEHAVIOR	HIGH-RISK CLIENTS	INDIVIDUAL IN CRISIS	TARGETED GROUPS	GENERAL POPULATION
NEEDED	- Linkage, placement and case management - Rehabilitative & habilitative care - Clinical maintenance and advocacy	- Protected care	- Rehabilitative & habilitative care		
OPTIONAL	- Consultation, education & community outreach	- Consultation, education & community outreach	- Protected care - Sheltered, supportive care - Linkage, placement and case management - Clinical maintenance and advocacy - Consultation, education & community outreach	- Linkage, placement and case management - Crisis counseling and intervention	- Consultation, education & community outreach

* Consultation, Education and Community Outreach Services are essential for ethnic and minority groups, who do not use traditional mental health resources because of historical, cultural, and linguistic reasons.

IDENTIFY TRENDS AND CONSTRAINTS

- Insufficient state C.O.L.
- Medi-Cal restrictions and cost containments
- Rising cost of local acute hospital care
- Restricted access to state hospitals
- Fixed state hospital day allocations with fiscal penalties
- New state funding tied to reduction of state hospital allocation
- Possible reductions in state and federal allocations
- Increase demand for mental health services

DEFINE PRIORITY POPULATIONS AND BASIC SERVICES

Priority Populations

- Life-threatening behavior
- High-risk clients
- Individual in crisis
- Targeted groups
- General population

Basic Services

- Protective care
- Sheltered, residential care
- Linkage, placement, and case management
- Rehabilitative and habilitative care
- Clinical maintenance
- Crisis counseling
- Clinical assessment and disposition planning
- Community outreach services
- Information and referral

MATCH CURRENT PROGRAMS TO PRIORITY POPULATIONS AND PRIORITY SERVICES

BY ASKING CRITICAL EVALUATION QUESTIONS SUCH AS:

I. Who is being served?

- age
- ethnicity
- diagnosis
- financial responsibility
- census tract
- other mental health treatment
- prior admission

II. What services are being provided?

- group
- individual
- medication
- duration of treatment, etc.

III. How well managed is the program/service impact?

- cost/reimbursement effectiveness
- staff productivity
- caseload size
- number of open admissions
- number of unique clients served
- service impact

MAKE DECISIONS ABOUT PROGRAM CHANGES

- Reallocate
- Reduce
- Consolidate
- Eliminate
- Expand
- Modify